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BULLETIN

THE MAHONING COUNTY MEDICAL SOCIETY
Volume LIX Number 8 November 1989

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BULLETIN

MAHONING COUNTY MEDICAL SOCIETY

Volume LIX November 1989 Number 8

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1989 MAHONING COUNTY MEDICAL SOCIETY MEETINGS

Tuesday - Jan. 21
Tuesday - March 21
Tuesday - May 23
Tuesday - September 19
Tuesday - November 21
Tuesday - December 19

The Bulletin is published nine times a year monthly with the exception of May, July & August, by the Mahoning County Medical Society, 5104 Market St., Youngstown, OH 44512. Ph. 216/788-4700. Eleanor Pershing, Executive Director

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President's Page

Karl F. Wieneke, M.D.

Does Quality Assurance Assure Quality?

"Quality Assurance fever is spreading rampantly through the ranks of hospital administrators, health-care regulators, J.C.A.H.O. and other similar reviewers, and medical chiefs of staff. Its symptoms include compulsive scrutiny of departmental staff minutes, expansive filing of material into staff personnel folders, frenzied xeroxing of data and calculation of statistics, and wanton organization of new committees to review the work of the first sets of committees. Although the attention to Quality Assurance appears to be increasing exponentially, it is still too soon to predict its ultimate outcome."

Thus begins an editorial written by Dr. Bernard M. Jaffe, Professor and Chairman Department of Surgery, State University of New York, Health Science Center at Brooklyn, New York and published in a recent issue of *Surgical Rounds.* His editorial is so timely and to the point that it is worth while reprinting exerpts here. Dr. Jaffe continues, "Although it is quite clear that there is a need for an effective review process, it is our responsibility to determine whether Quality Assurance as it is currently constituted is the best available technique. In other words, does Quality Assurance assure quality?"

Because the strengths and advantages of Quality Assurance are so well recognized there is no reason to discuss them. Instead, the potential problems with the process need to be emphasized.

Quality Assurance has become such an established entity that it has developed a life of its own. It has formal rules, an expected structure, and an extensive new vocabulary. Originally established to assist hospitals in the monitoring of the level of care provided, unless there is a change from its current course, this process ultimately may dominate the hospitals it was created to serve. It already has gone far beyond peer review such that it is sometimes difficult to discern whether a hospital surveyor is more interested in the qulaity of care or in the quality of Quality Assurance itself! The danger of this perception is that physicians and hospital administrators may focus more of their attention on improving Quality Assurance as a process rather than striving to improve the level of care—in other words, treat the charts rather than the patients.

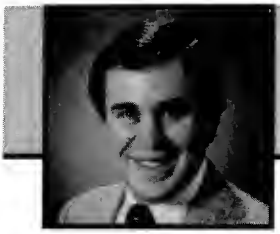
Maintaining an effective Quality Assurance process is very expensive. It commands a huge bureaucracy, including chart reviewers (a new profession that steals nurses from the bedside), hospital administrators (particularly, newly created specialists in the field), secretaries, and many others. It generates a gigantic amount of typing, filing, xeroxing, and distributing of paperwork. It absorbs enormous amounts of physician time, diverting doctors from other clinical obligations. At a

time of continuing escalation in health-care costs, we have to set priorities. Is Quality Assurance really cost effective? Is it the best way to spend precious limited recourses?

Under Quality Assurance guidelines, every adverse outcome is investigated in an attempt to determine whether the level of care provided was appropriate and, if not, who was responsible for the problem. Because few, if any, patients are cared for by only one physician or one service, these investigations can be extremely divisive, particularly as the penalties against implicated physicians mount. In whose interest is it for a surgeon to argue with an anesthesiologist about who is to blame for an intraoperative complication? Or, to disagree with an internist as to the effect of timing of intervention on a patient's ultimate outcome? Certainly not the patient's! But, rather than inspiring a spirit of cooperation and community, Quality Assurance, with its attendant adverse actions, fosters self-protection and denial of guilt. Although this is clearly neither the intent nor the desired result of the process, it can easily be understood in terms of the natural human instincts for self-preservation.

Finally, Quality Assurance discriminates against physicians in two subtle ways, both of which put physicians in possible jeopardy. First, Quality Assurance does not equally challenge the hospital's role in poor patient outcomes. Although this process initially was designed to be run by physicians, it is now largely a hospital function. Accordingly, physicians are potentially vulnerable as scapegoats for institutional frailties. Second, Quality Assurance is unique in that it assumes that the physician is guilty until proven innocent. When a reviewer (usually a nurse) identifies a perceived problem, the process initiates a review, usually starting at the department level. There are now requirements in many states that a notice be placed in the physician's file that such a review is underway. Although the physician may be totally exonerated by the subsequent steps, until this occurs, the paper trail attests to his or her culpability. And, although Quality Assurance documents are supposed to be protected, I know of several circumstances in which they were not.

Thus, although peer review is a vital component of our professional responsibility, Quality Assurance, despite its many positive attributes, is a flawed system. It is expensive, divisive, misdirected, and discriminatory. We may have to learn to live with its problems, but only if objective assessment documents that it is the best mechanism to accomplish the peer-review goal. During the next several years, it's imperative that we work to clean up the process while we collect the data necesary to determine if Quality Assurance *really* assures quality.



From the Desk of the Editor

Brian S. Gordon, M.D.

Peer Review and the Elderly Physician

About 100 years ago Keiser Wilhelm designated the age of 65 years old and older as being elderly. We still use this as criteria for designating what is, and what is not considered old in our society. Through the advances in making life physically better, even though it is more complex, and with the huge gains in medical care as well as technologies, the elderly are gaining rapidly in numbers. It is shown statistically that 1600 more people become elderly than die elderly each day. In the year 1900 only three million Americans were at least 65 years old, and in 1985, 28 million Americans could claim to be elderly. It is estimated that by the year 2030 when the baby boomers are elderly, the elderly population will skyrocket to 58 million. This translates into a current expenditure for health care of one-third of the current total expenditure to nearly one-half by the year 2020. Despite the huge emphasis on the elderly, our society is not ready at this time to deal with the problem. Medicare and Medicaid supports these people in some way as well as thousands of volunteer and local organizations. Gerontology as a field has grown tremendously in the meantime despite a multitude of available resources. The reason for this probably is because of our youth oriented society. Big business promotes creams, dyes, dentures, hearing aids and other devices to remain youthful. It is therefore, not unfitting that peer review groups have also looked at the problem and have decided that those who have studied medicine, probably 30 to 40 years earlier have fallen behind the times and should be looked at more closely. There is precedence for this since in many states even automobile drivers have to be tested over the age of 65 every year in order to retain their drivers license. There is now a call for some type of testing to make sure that elderly physicians are capable of practicing medicine on at least a base level for their specific field of interest. It is seen in many reviews that these physicians tend to delay treatment until the patient becomes more advanced and then have a greater percentage of misdiagnosis waiting for specialists to make the diagnosis for them. Additionally, there is a problem in many hospital systems where elderly physicians consult many subspecialists but fail to have the knowledge to manage the whole case as a unit coordinating the studies and advice of his consultants. How should these tests be given if given at all? Should they be given on a yearly basis? Five year basis? Or ten year basis? What information would we want to be gleaned from this, and what to do with the results once you have them? As disgusting as it might seem, hospitals will be forced to take a greater look at all physicians within their hospital, especially the elderly physicians because of inherent liabilities. In our youth oriented society, the growth and complexity of medicine is burgeoning at an unprecedented rate. Allthough it may have been possible in the past for an elderly physician to practice almost the same way he did when he began practice, it is impossible for him to do that at the present time. In upcoming meetings through the OSMA and the AMA, these questions will be discussed in part if not in whole. If you have a particular opinion about this please contact your local OSMA representative or AMA representative because these are the people who will help influence the legislative portion of peer review.

Medical Decision Making

Leonard P. Caccamo M.D. FACP

Aphorisms, Rules of Thumb and the Analytic Approach

Leonard P. Caccamo M.D.
Kimbroe Carter M.D.

During the teaching of clinical problem solving students are instructed to gather large amounts of data in the traditional manner, previously referred to as the "Method of Exhaustion". Such information is often redundant and places much emphasis upon unstructured data gathering at the expense of pattern recognition and the generation of hypotheses. Without "disciplined thinking" there exists no quantitative strategy to weigh "high yield" alternatives and select which pathway is most appropriate. More importantly such traditional methods often fail to incorporate individual patient desires and preferences into the decision process. This later activity is critical for adequate patient education, informed consent and patient compliance.

Establishing a differential diagnosis is, in a sense, a learned discipline. However, the real challenge lies in taking a limited amount of perceived information and formulating an accurate hypothesis with reasonable alternatives and testing the strength or robustness of such hypotheses. This process constitutes the science of decision analysis. The thought mechanisms that trigger accurate hypotheses from minimal external information still remain unexplained and as mystifying as they were decades ago. However, the diagnostic process has been modeled and succinctly portrayed by the Decision Funnel in last month's article. It appears that pattern recognition stimulates hypothesis formulation early in the physician patient encounter. Tenable hypothesis are constructed and then challenged at each step in the diagnostic process, in order to strengthen or refute the working hypothesis under consideration.

Dreyfus and Dreyfus make a compelling case that computers employed as logic machines will always be subordinate to proficient and expert clinicians, who utilize intuition, reflection and past experience.[1] These special talents, most evident during the early phases of diagnostic reasoning, reflect instinctive disciplined thinking. Modeling may be performed by proficient and expert physicians at either the conscience or subconscience level. Their insight and assistance in constructing decision trees, identifying and valuing outcomes is essential. One can not educate the student, resident or practicing physician to attack problems armed only with "machine-like logic" without the benefit of experienced learning from Master Clinicians. Medicine still remains the most humane of the sciences and the most scientific of the humanities.

However once the process has been narrowed to a specific hypothesis (point B in the decision funnel), various models can then be effectively utilized for process-

ing the decisions to OBSERVE, TREAT, TEST, and assist patients in making value judgements and informed choices, (PATIENT EDUCATION). It is here that decision analysis and computer programs for decision making may prove of immense value not only in the classroom and hospital, but also in the physician's daily office practice!

What exactly does decision analysis do? It uncovers biases affecting traditional clinical judgement and makes assumptions explicit. It quantifies probabilities and values associated outcomes, while providing mathematical methods for weighting, integrating and analyzing these variables.

A. THE DANGERS OF PRESUPPOSITIONS AND THE USE OF HEURISTIC

The traditional approach to teaching, mentioned previously, sharpens information gathering skills of the student physician. Such efforts, however, are not goal directed and fail to effectively utilize a disease hypothesis that can be substantiated or refuted while collecting data. On the other hand, the analytic process is goal directed and structured around cognitive heuristic or pragmatic "rules of thumb", that can protect the proficient physician from judgmental error and biases. Students and residents need instruction concerning the dangers of such errors or presuppositions from which they generate clinical assumptions. Bateson feels that those who lack the idea that their belief systems may be initially wrong can learn little but technical skill. [2]

What are some of these hazards of clinical judgement? Clinicians often ignore the PREVALENCE of the disease within the population from which the patient comes. They may use low grade information to represent disease while accepting false reassurance from redundant predictors. The unwary may either over or undervalue the frequency of a particular clinical finding. The misleading effects of a recent experience including an unusual case, a lecture or current journal article often enhances the consideration fo a particular disease. In addition the undisciplined also fail to adequately adjust frequency estimates when presented with new test information.

In contrast astute master clinicians utilize a set of unstructured "rules of thumb" (heuristic) in a subconscious or intuitive manner to effectively solve problems while avoiding dangerous presuppositions. Over the years their students have often recorded a number of "clinical pearls" and other pithy aphorisms that describe the intuitive "leaps" employed by these teachers and master physicians.

Let us pause a moment to define the following useful terms:

RULE OF THUMB: a mental process used to learn, recall, or understand knowledge.

HEURISTIC: "A rule of thumb"

APHORISM: a unique way to introduce a "rule of thumb." Its purpose is to provide a truth or well held opinion. It helps teach disciplined thinking.

In medical decision making they are pithy distillates of clinical experience.

CLINICAL PEARL: a finding which helps make a diagnosis. (Harvey)

Important clinical heuristics have been classified by the cognitive scientists. Interested individuals may profit by attempting to relate these arcane cognitive terms with examples of some well known clinical aphorisms. This effort may well result in greater understanding and the generation of a meaningful classification:

B. THE REPRESENTATIVE HEURISTIC AND ITS APHORISMS

This "rule of thumb" indicates that when assimilating new evidence physicians seldom take into account the frequency rate with which certain events occur. The prevalence of a disease within a community is often ignored and too much weight placed upon new evidence suggesting a more unusual disorder. The following numbered aphorisms speak clearly to this problem:

#1 "Common things are common"!

#2 "If you hear hoofbeats, think horses, not zebras." [3]

#3 "Rare manifestations of common diseases are more likely than common manifestations of rare disease"

#4 "If it looks like a duck, walks like a duck, quacks like a duck, has feathers and lays eggs, it is most likely a duck, not a zebra" [3]

C. SERIOUSNESS AND TREATABLE PATTERNS EXPRESSED IN APHORISMS:

#1 "The first priority in differential diagnosis is to think about the (serious and treatable) problems you can't afford to miss." Sox [4]

D. REGRESSION TO THE MEAN APHORISMS

Laboratory results have never been, and will probably never be, fixed but are rather subject to random variation, often dispersed about a mean or average value in a somewhat symmetrical curve. Clinical pathologists are well aware of the fact that the normal range of laboratory findings conventionally exclude the upper and lower 2.5% of results at the extreme ends of a normal curve. Therefore 5% of the normal population may be labeled abnormal. In a disease state abnormal values tend to persist, while in healthy patients the test results, upon repetition, tend to approach the normal mean. Thus an "abnormal" value may be the result of nothing more than a random variation.

#1 "If a test result surprises you, repeat the test before taking action." (Example making a diagnosis of diabetes only to find upon repeat testing that the hyperglycemia is not present!)

E. THE AVAILABILITY HEURISTIC AND ITS APHORISMS

The probability of the event is judged by the ease with which the event is remembered. Here data concerning an unusual case either from personal experience, a recent journal article, or grand rounds, is often applied to the diagnosis out of proportion to the likelihood of its occurrence rate.

#1 "Diseases are found in textbooks, illnesses in patients!"

F. THE ANCHORING AND ADJUSTMENT HEURISTIC AND ITS APHORISMS

Physicians initial probability estimates tend to be too extreme, too close to 1 or too close to 0.

#1 "Some of the greatest mistakes I have seen in medicine have occurred when one physician accepts the negative findings of another without re-examining the patient." Jeghers

#2 "An acute illness in a young patient suggests a single disease" Rule of Parsimony

#3 "In older patients a single explanatory diagnosis may not be possible since there is often more than one disorder present." Harrison's Pearl

#4 The White Bear Syndrome: "If someone tells you to go in the corner, close your eyes and don't think of a white bear...you will be unable to think of nothing else but a white bear". In medicine this occurs in three circumstances. (1) When asymptomatic subjects with a disorder are examined in a situation where the routine nature of the examination crowds out anticipatory thoughts of abnormality. (2) When symptomatic patients have co-existing disease which produces similar symptoms and masks the imporatnt underlying disease. (3) When the referring physician has seen the patient and prejudices the second physician. [5]

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55 ACRES, $35,000

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News from NEOUCOM

Brendan P. Minogue, Ph.D.

Contemporary Medical Ethics

The growth of medical technology has been the primary reason for the expansion and development of medical ethics during the past 20 years. Respirator ethics, genetic counseling, informed consent, reduced levels of therapy, the allocation of scarce medical resources, and the "right to die" are just a few of the topics covered under the umbrella of medical ethics.

We in Mahoning County are a part of this technological development and, therefore, must face the new ethical challenges precipitated by contemporary medical science. To confront these challenges, Youngstown State University, in conjunction with the area hospitals and the medical school, has developed a number of very active programs in the area of medical ethics.

As a philosophy professor at Youngstown State, the programs I find most intriguing are the ones involved in teaching medical ethics to health care professionals. Our Phase I medical students from Northeastern Ohio Universities College of Medicine now are required to take a medical ethics course during their first two years in the program. But we are not just giving them a course and considering our job done.

We are beginning to bring medical ethics into the medical rotations. For example, when medical students are in their internal medicine rotation, they must develop a medical ethics case "workup" in which they are asked to identify an ethically troubling case and address both its medical and ethical aspects. The students are assisted in their workup by a staff physician and an ethicist, and they must be prepared to respond to both medical and ethical issues of the case.

The students have found this "hands on" approach to medical ethics challenging, but also feel it vitalizes purely academic ethical questions.

Finally, in their last year, students in our medical college are required to do a "Human Values in Medicine" rotation that challenges them to return to the humanities and social sciences after their medical rotations. The purpose of this rotation is to encourage them to examine medicine from a human, rather than a purely technological, viewpoint.

While education is primary, it is not all that is involved in contemporary medical ethics. A few years ago I was asked to join the Western Reserve Health Care System as medical ethicist. The most common question asked me by physicians and nurses is "What does a hospital ethicist do?"

As I see it, there are basically two responsibilities: policy development within the ethics committees, and hospital-based education. At Western Reserve we have

at least three ethics committees: the hospital ethics committee, the pediatric ethics committee, and the institutional review board.

These committees are now commonplace on the American medical landscape and their functions are to serve as sources for developing policies on such issues as withholding treatment, withdrawing treatment, .palliation, human subject research, etc. These policies spell out a hospital's "philosophy" on these tough issues.

These policies do not replace physician judgment and individualized treatment for patients, but they can provide useful guidelines within tough cases. The ethicist at the hospital plays an important role in the development of these policies.

Secondly, policies that lie comatose inhospital handbooks and do not impact patient care are worthless. Education on the policies is essential. The hospital ethicist organizes and, in some cases, leads the discussion of these issues.

Perhaps the most important misconception of the medical ethicist is the view that he or she is the one with all the answers to the tough questions facing medicine in the twentieth century. Nothing is further from the truth. Philosophers can lead the discussion of the issues; they can raise the important questions; they can organize opinion around shared values; but the job of developing responses to the challenges that we face is one that must be shared by citizens, health care profesionals, and patients.

Dr. Minogue is Professor of Philosphy & Religious Studies
Youngstown State University

From the Bulletin

Robert R. Fisher, M.D.

Fifty Years Ago - November 1939

President Bill Skipp gave thanks for the observance of the Code of Ethics which had produced such a fine standard of conduct among our members. Dr. James Fisher submitted a lenghty article on the history of blood transfusions.

Forty Years Ago - November 1949

President Dr. John McCann urged everyone to support the Community Chest. His advice still stands. Health Commissioner, Dr. Walter Tims, was promoting a rat control program. When they closed the City Dump, all the rats moved out into the adjacent neighborhood.

ThirtyYears Ago - November 1959

Dr. Carl A. Gustafson was honored at the Sixth District Assembly dinner for his faithful service as Sixth District Councilor for six years. Dr. Angelo Riberi had a leading article on his experience with "Superior Vena Caval Replacement". Dr. Winifred Liu Mutchmann had an informative article on "Pre-Invasive Cervical Cancer and the Schiller Test". Dr. Robert L. Jenkins wrote about the role of Mahoning County in a nationwide study by the American Cancer Society.

In a poll of the members, 84.6% of those who replied were in favor of Social Security for Physicians.

Twenty Years Ago - November 1969

President Dr. Joe Tandatnick wrote about the problem of caring for the poor. "—and were we —[able] with tremendous effort, to improve medical care for the poor— the basic problem would be far from being solved". And he went on to cite unemployment, inadequate housing, malnutrition, where he placed the blame on the government

Editor, D.J. Dallis, wrote about the problems of dealing with narcotic overdose patients in the emergency ward. His theme was that he felt that marijuana use led to stronger drug use, and that marijuana use should not be legalized.

New active members that month were Dr. Robert Gilliland and Dr. Ronald Roth. New associate members were: Dr. Bruce Lipton, Dr. Lawrence Pass, Dr. Felix Pesa and Dr. Sarah Yacono.

Ten Years Ago - November 1979

The regular November meeting was moved up one week to accomodate the speaker, Sen. Harry Meshel. After going to all that trouble, they never printed one word about what he had to say.

Dr. Suman Mishr was elected president of the Mahoning County Chapter of the American Diabetes Aasociation. Dr. Ravinder Nath became a diplomate of the American Board of Internal Medicine. Dr. Simon Chiasson was chosen president-elect of the American Society of Clinical Hypnosis. Dr Nathan Belinky was reappointed to the advisory board of the International Association of Coroners and Medical Examiners.

There were no new regular members that month. New Associate Members were: Vincent Lawrence Hennessy, M.D., Khalid Iqbal, M.B.B.S., Anil C. Nalluri, M.B.B.S., and Frank A. Rich, D.O.

COPPER WADE CLASSIC

Overlooking a boulevard of plush flowering crabtrees, just a jaunt from the beauty of Millcreek Park, this distinguished colonial of Philadelphia cut stone and frame offers many new features for today's living. The new custom cherry kitchen with Jennaire and Pella Windows leads to the 16x24 ft. studio enhanced by skylights and cherry woodworking, hardwood floors, deep crown molding, a 14x16 ft. dining room and gracious foyer are all reminders of how it used to be. The knotty pine family room with built-ins and sunken living room with 2 fireplaces lead onto a spacious screened in porch overlooking the 182 ft. landscaped lot with lower level patio. Four bedrooms, 2 full and 2 half baths, as well as, a rec room with fireplace will provide your family with something for everyone. For additional information and your own private viewing, call Karen Syrakis, Burgan Real Estate, Ltd. at 783-0055 or 788-5050.

The Associate Dean's Column

Gene A. Butcher, M.D.

Where Do we Go From Here With Graduate Medical Education?

On September 29, 1989 the Health Care Financing Administration published its final regulations implementing Medicare's methodology for paying teaching hospitals for the cost of training residents. The regulations implemented a statute passed by Congress in April of 1986 aimed at limiting the growth in Medicare expenditures for Graduate Medical Education (GME). Under the regulations the current pass through for GME cost is eliminated. Instead, the GME reimbursement hospitals receive each year is a prospectively determined GME cost per resident. The cost per resident in the base year 1985 is multiplied by the hospital's weighted number of residents for the current year. This new system is effective retroactively for all cost reporting periods beginning on or after July 1, 1985. The regulations do not apply to other types of medical education expenses; for example, approved nursing or allied health professional programs. The regulations also do not apply to the indirect medical education adjustmant factor which hospitals receive under their DRG formula.

This government plan to reduce spending for GME will have significant consequences for the medical profession, practicing physicians and teaching hospitals. Added to the pressures that are increasing the competitiveness within the health care industry, lower reimbursement for GMEwill force changes in the way-medical education is taught and in the traditional relationships between residents and practicing physicians in the teaching hospital. In the 1950s and 1960s, government financial support expanded the number of hospital beds. It increased the supply of physicians in an effort to expand accessibility of health care to all its citizens. Federal support was made available to assist new medical schools and capitation grants were awarded to schools that agreed to increase enrollment. Medical school enrollment increased from 8,964 in 1966 to a peak of 17,320 in 1981.

Recent changes in the health care environment have led to the reversal in this rate of growth. After publication of the GMENAC report in 1980, federal policy shifted from one of concern over the shortage of physicians to a concern about over supply. Support for teaching and post graduate training declined almost immedi-

ately and continues to be threatened by these Medicare cost reduction proposals that have recently been introduced. The federal government has been considering proposals to reduce its reimbursement for indirect medical education costs from the current level of 7.7% to 4.05%. While it is unlikelywith the lobbying efforts of AAMC andmedical schools that the cut will reach this level, it is unrealistic to hope that the 7.7% current reimbursement rate will continue. Each 1% reduction in the indirect teaching adjustment by HCFA will result in a $250 million dollar total reduction and $1-4 million dollars in lost revenue for most teaching hospitals.

The fact remains that GME programs continue to be a source of great pride to their sponsoring hospitals and a significant resource to practicing physicians and the community in general. However, due to government and other payors' efforts to reduce GME funding, teaching hospitals will be facing increased operating deficits putting them and their medical staffs at tremendous competitive disadvantages when it comes to medical education.

As teaching hospitals cope with financial regulatory and competitive pressures in the industry, their management will need to closely address what the true cost and benefits of delivering graduate medical education are at the institution. They must also closely evaluate how the hospital can respond to cutbacks and funding for GME and maintain the service levels and the educational component expected by its medical staff, the patient population and the accreditation body. In evaluating the alternatives for GME, hospital administrators and clinical chairmen could realize significant benefits from comparative clinical and financial information programs at other institutions. Such a program has already begun at NEOUCOM to examine how graduate medical education monies are spent and how the hospitals have responded to meet the already significant pressures on cutting graduate medical education reimbursement.

What are the implications for the physicians who admit patients to teaching hospitals? A number of possible scenarios and impacts on current practice patterns are foreseeable. A cutback in GME programs and residency positions could leave hospitals with gaps in floor coverage that would have to be filled by practicing physicians, physician assistants or paraprofessionals. Current physicians in this community who are used to having medical resident coverage on their patients will find that they will have increased responsibilities in the hospital in completing histories and physicals, caring for their patients and participating much more closely in patient care. It might also be anticipated that physician assistants and other para-

professionals may need to be used to fill some of the service duties which residents have historically supplied in our local institutions.

It also may be that residents will be asked to take on a larger share of the cost associatedwith graduate medical education further increasing their current debt position. Most GME programs bestow intangible benefits such as prestige and an image of high quality care to their respective institution. Physicians may be asked to make larger contributions to the hospital to reflect these advantages particularly when it comes to their time and effort in maintaining a teaching program. Furthermore, a decline in the number of graduate trained physicians could have significant impacts on the delivery ofmedical care in this country including increased practice volumes, greater and more diverse demands for physician time and an increase potentially in the growth of group practices to meet the increasing demands on the solo practicing physician.

Summary

A commitment to GME is an extremely sensitive and complex issue. Given the potential reimbursement regulatory and competitive changes ahead, it is clear that all teaching hospitals will need to address this major strategic issue which lies ahead for us. How much they will be able to reduce their financial exposure and preserve their current market positions will depend upon how effective they are at changing medical practice and current educational practices in the training of young physicians.

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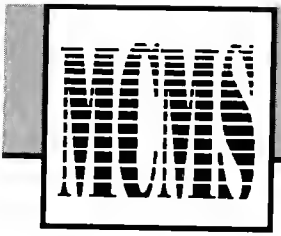
ROBERT SCHEIG, M.D., Professor of Medicine, State University of New York at Buffalo, Head, Department of Medicine, Buffalo General Hospital, Buffalo, New York, a MERK, SHARP & DOHME Visiting Fellow, *""Comparative Pharmacology of Agents Affecting Hypercholesterolemia"*

December 22, 1989 ..... CHRISTMAS HOLIDAY
No Program Scheduled For This Date

December 29, 1989 ..... NEW YEAR'S HOLIDAY
No Program Scheduled For This Date



Meetings

Society Meeting

The November meeting, attended by 87 members and guests was held on Tuesday, November 21, 1989 at the Youngstown Club. Two applications for resident membership, Perry D. Mostov, D.O., and David M. Kennedy, M.D., were approved. Members requesting Emeritus status were noted (Drs. A.V. Banez, R.R. Fisher, W.D. Loeser, W.T. Martin, R.E. Pedraza, H. Queen) and two new members, Dr. George Spirtos and Manuel Spirtos were introduced. Also attending was Dr. Robert Taylor, president of the Trumbull County Medical Society.

The Nominating Committee report was presented and candidates nominated by the membership are:

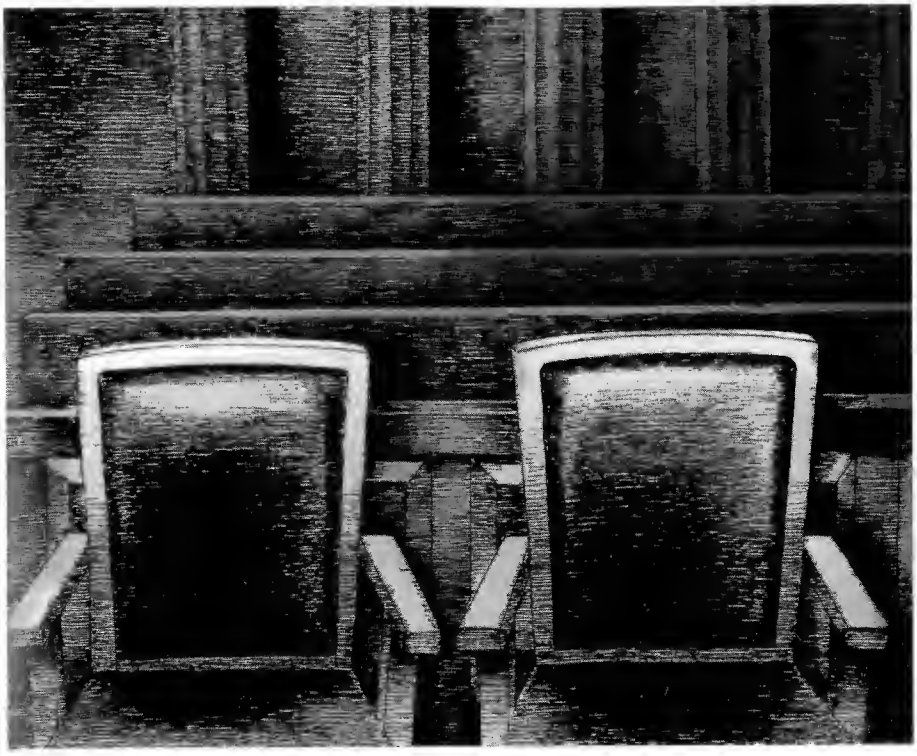
President	J.A. Lambert, M.D.
Vice-President	B.S. Gordon, M.D.
Secretary	K.J. Carter, M.D.
1994 Delegate	K.F. Wieneke, M.D.
Alternate Delegate	E.V. Angtuaco, M.D.
(2 to elect)	M. Guthikonda, M.D.
Council Member at Large	J.W. Babyak, M.D.
(5 to elect)	D.J. Dunch, M.D.
	J.G. Guju, M.D.
	A.M. Qadri, M.D.
	E.W. Svenson, M.D.
Foundation Trustee	A.W. Geordan, M.D.
(2 to elect)	V.D. Lepore, M.D.

The election will take place at the Annual Meeting on December 19, 1989. The meeting concluded with a presentation by Attorney Jack T. Diamond, health-care law specialist, Buckingham, Doolittle and Burroughs of Akron, Ohio, whose topic was "Recent Changes in Health Care Law". He gave an update on Peer Review Organizations and listed strategy in dealing with PROs.

Council Meeting

The following application was presented and approved during the Nov. 14, 1989 meeting of Council. The applicant will become a member of the Mahoning County Medical Society 15 days after his name has been published in the November issue of the Bulletin that is mailed to all members, unless an objection is received in writing by the executive director before that effective date

First Year In Practice: Frederick G. Kury, M.D.



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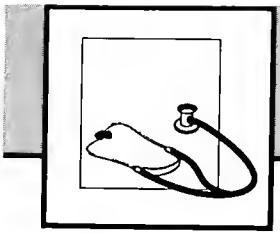

Employee evaluation as a motivational tool.

When increasing a staff member's pay, use the occasion for a confidential evaluation session. It creates a motivational tie between quality of work, employee gratification and salary.

Physicians are notoriously poor in the handling of pay raises for their assistants. Even very generous increases are often decided upon casually, followed by off-hand statements like "I'm raising your pay by $15.00 a week starting next week". Sometimes we even hear of practices in which pay raises simply appear on checks at the new salary levels, with no spoken words at all.

Special Process

Instead, make sure that each employee's salary increase is accompanied by a confidential discussion. Explore the job performance since the last evaluation, and then conclude the session by linking the new salary to the quality of work performance. This way, compensation plays an important role – rewarding the employee for her work and motivating her to continue striving for improvement.

So many staff members have told us that "No one ever tells us we're doing a good job." That is indeed unfortunate, for psychologists rank sense of acomplishment as a strong motivational factor in employment. Since good medical assistants can fairly easily find comparably paying positions these days, making them feel appreciated for their work becomes more important than ever. It isn't difficult to be considerate, and the periodic evaluation session/pay raise attempts to assure that appropriate attention is paid to your employees' fellings.

Poor Performance

Of course, the evaluation can have an opposite (but useful) effect on a less than fully satisfactory assistant. Honest discussion of deficiencies, followed by granting a less generous salary increase, puts that employee on notice to improve or look for other work. Such a discussion is fair to the employee involved as well as to the practice. And of particular importance, it helps you maintain credibility with your really good employees.

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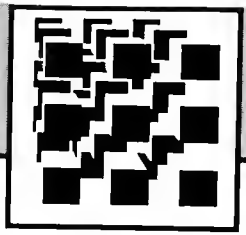


Western Reserve Care System-CME

December 12, 1989 - 8:00 a.m., Emergency Medicine Lecture Series, "Fractured Hips: Current Therapy and Diagnosis", Raymond Duffett, M.D., Orthopedic Surgeon, Western Reserve Care System, Medical Education Center - Northside Medical Center

December 13, 1989 - 4:00 p.m. , Pathology Grand Rounds , "Diagnostic Tests Using Polymerase Chain Reactions", Yuel D. Tom, M.D., Assistant Professor of Pathology, NEOUCOM, Pathologist, Western Reserve Care System, Administrative Conference Room - Northside Medical Center

December 14, 1989 - 8:00 a.m., Internal Medicine Grand Rounds, "The Management of Advanced Breast Cancer" Charles L. Vogel, M.D., Clinical Assistant Professor of Internal Medicine, University of Miami School of Medicine, Medical Director, Comprehensive Care Center, Miami, Florida, Hitchcock Auditorium - Southside Medical Center

December 14, 1989 - 8:00 a.m., Pediatric Grand Rounds, "Psychosocial Dwarfism", Dorothy J. Becker, M.B.B.Ch., Associate Professor of Pediatrics, University of Pittsburgh School of Medicine, Pediatric Endocrinologist, The Children's Hospital of Pittsburgh, Pittsburgh, Pennsylvania, Medical Education Center - Northside Medical Center

December 16, 1989 - 8:00 a.m., Anesthesiology Lecture Series, "Anesthesia and Anaphylactic Reactions" Shaun A. Hennon, M.D., Anesthesiologist, Western Reserve Care System, Anesthesia Conference Room, Northside Medical Center.

December 16, 1989 - 8:00 a.m., Tumor Conference, Douglas J. Smith, M.D., Moderator, General Surgeon, Western Reserve Care System, Hitchcock Auditorium, Southside Medical Cente

LEGISLATIVE NOTE FROM MCMSA

"Forgiving" a portion of a medical fee — traditionally the portion not paid by Insurance, must be considered carefully. Although the author may be considered to be presenting the worse case scenario, any practice of fee reduction should probably be considered in consultation with a health care lawyer and any office personnel who have responsibility for discussing fees with patients must actively be brought into the process to make certain that what everyone is telling patients is appropriate.

Susan Katz,
Legislative Chairman, MCMSA

"In the medical profession, the day of the good guy has passed. Thanks to the insurance industry, a venerated custom is now considered grounds for criminal and civil prosecution.

"Have you ever been in the position of having a doctor discount his bill? Under these circumstances, he might say: 'Don't worry about paying me. I'll accept whatever your insurance allows for my fee.' I've done it hundreds of times and most doctors I know do it, too. Consider the case of an elderly widow on a pension. I admit her to hospital for treatment of pneumonia and I send a bill for reasonable charges to Medicare. She doesn't have the extra money to pay me, and I have no intention of billing her. In a sense, I'm lucky because, 25 years ago, I would have treated her for free. However, under today's regulations, I could be thrown in the hoosegow if I don't collect from her.

"In the past, the system of fee-forgiveness worked well. People paid what they could and the doctor forgave the rest. If the patient was fortunate enough to be covered by health insurance, including Medicare, the doctor billed the insurance company and accepted as full payment whatever the insurance allowed.

"Today, this courtesy is dead. The doctor who forgives part of a fee runs the risk of being prosecuted under the Racketeer Influenced and Corrupt Organization Act, which mandates that alleged overcharges be tripled as fines. Here is how RICO puts the squeeze on patients. (Emphasis added.)

"Let's say the doctor bills you $100 for a service. You have the health insurance that pays 80 percent of the fee, or $80. Because you have a limited income, the doctor is willing to accept the $80 as full payment, rather than having you pay the additional $20 co-payment. You obtain the service you required, the doctor gets a portion of his usual fee, everybody's happy. Right?

"Wrong. The rules have changed. Today, the insurance companies claim that because the doctor accepted $80, he was actually charging $80, not $100, for the service. Therefore, the insurance pays 90 percent of $80 or $64. The $16 difference is viewed as an overpayment by the insurance carrier. Under RICO, the $16 is trebled and all hell breaks loose. Multiply that innocent $16 by enough patients, and insurance companies become very interested, you see. The patient doesn't think the arrangement is fraudulent, the doctor believes he is merely being compassionate -- but insurance companies consider it criminal.

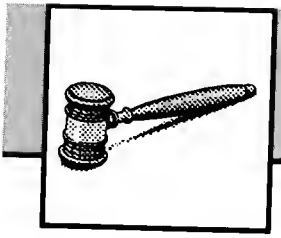
"No one knows how much of the $50 billion a year in insurance fraud is made of co-payment forgiveness. However, it's enough for the companies to go after doctors. According to James Norman, writing in a recent issue of Medical Economics, 'some insurers take the hard-line position that physicians don't have the right to forgive co-payments even occasionally -- not for indigents, not for colleagues, not even for their grandmothers.' (Emphasis added.)

"CIGNA, the insurance giant, recently wrote a letter to physicians, which included this statement: 'no claims submitted by you can be processed until we receive a signed certification from you that the charges shown on claim forms are your actual charges, and that patients will be required to pay amounts such as co-insurance and deductibles.' This is not a nickle-and-dime issue. Metropolitan Life Insurance Co. is suing a dermatologist for $900,000. (Emphasis added.)

"In all fairness, I must point out that physicians are not blameless for this unhappy state of affairs. Some doctors have been gouging insurance companies for years, by inflating fees, upgrading codes for services, adding fictitious services, or advertising that they forgive co-payments -- in desperate attempts to attract patients. They should be punished.

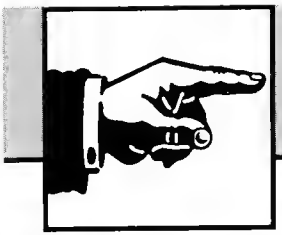
"Nonetheless, I'm sorry to see yet another wedge placed between doctor and patient. It seems to me that physicians should have the time-honored right of forgiving fees in situations where there is financial hardship or other extenuating circumstances.

"However, under the threat of prosecution and severe penalties, I and thousands of other doctors are being forced to insist that patients pay their deductibles and co-payments. All of it. No more Mr. Nice Guy. Thanks a lot, insurance industry." GOTT, Dr. Peter, "Days of Doctors' Discounts Over, Thanks to Insurance Companies", The Ventura County (Calif.) Star Free Press, 16 July 1989.



Legislative Update

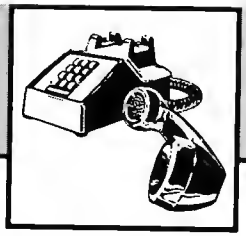
The Ohio State Medical Board has announced that it is creating an amnesty period for physician assistants who are currently practicing without being registered with the Board. Physician assistants are required by Ohio law to register with the Board, which is in effect now and lasts until February 28, 1990; unregistered physician assistants may register with the Board without fear of being cited for disciplinary actions for practicing without being registered. The Board still has the right to deny an applicant or to discipline for other reasons. Call the Board at (614) 466-3934 or the OSMA Department of Legal Services (800) 282-2712 if you have any questions.



Reminder

Effective December 1, 1989, physicians who treat medicare patients referred to them by other physicians are required to include the referring physician's Provider Identification number (PIN) on the HCFA 1500 forms. This means that the treating physician must have the PIN for all other physicians who refer patients to him or her.

To assist physicians with this requirement, the Mahoning County Medical Society has obtained a complete listing of providers in Mahoning County from the OSMA. Please call the office (788-4700) for your copy.



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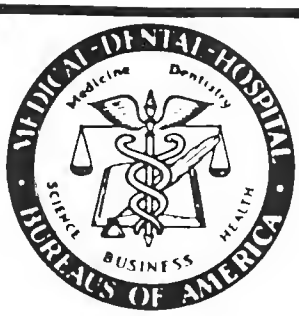

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